STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155321	A. BUILDING 01 B. WING	08/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	5544 E STATE BLVD FORT WAYNE, IN 46815

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/21/12 Facility Number: 000214 Provider Number: 155321 AIM Number: 100267240 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Miller's Merry Manor was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a walkout lower level was	K0000	**Please accept this plan as our credible allegation of compliance:**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	determined to be of Type II (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. Hard wired smoke detectors are installed in the resident rooms. The facility has a capacity of 77 and had a census of 52 at the time of this survey. The facility was found in compliance with state law in regard to sprinkler coverage and smoke detector coverage. All areas where the residents have customary access were sprinklered. The facility has a detached plastic shed used for oxygen transfilling and storage which is not sprinklered. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/27/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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K0018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. Based on observation and interview, the facility failed to ensure 1 of 14 resident room corridor doors on the 200 hall closed and latched into the door frame. This deficient practice could affect any of the 26 residents on the 200 hall. Findings include: Based on observation with the Environmental Supervisor on 08/21/12 at 12:08 p.m., the corridor door to resident room 214 failed to latch into the door frame. This was acknowledged by the Environmental Supervisor at the time of observation.	K0018	**K018** The door to room 214 was fixed on 8/31/12. All residents residing on 200 unit had the potential to be affected by this deficiency. The facility Maintenance Director or designee will complete a "Interior Room Door Inspection"(Attachment A) for each resident room by 9/20/12. The QA tool titled "Life Safety Review" (Attachment B) will be completed by the Maintenance Director or designee 2x weekly for 2 weeks, weekly for 2 weeks and monthly thereafter to ensure proper working order of our resident room door latches. Any issues will be logged on the QA summary log to be discussed at the monthly QA meetings. Corrective action will be complete	09/20/2012

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	3.1-19(b)		by 9/20/12	

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K0029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 4 corridor doors entering the kitchen, a hazardous area, were provided with self closing devices causing the door to automatically close and latch into the door frame. This deficient practice could affect residents in the main lobby. Findings include: Based on an observation with the Environmental Supervisor on 08/21/12 at 12:22 p.m., the two doors entering the kitchen from the main lobby lacked latching hardware and failed to latch into the frame. Based on an interview with the Environmental Supervisor	K0029	**K029** The doors between the kitchen and lobby will be equipped with latching hardware before 9/20/12. Any resident in the lobby area had the potential to be affected by this deficiency. The QA tool titled "Life Safety Review" (Attachment B) will be completed by the Maintenance Director or designee 2x weekly for 2 weeks, weekly for 2 weeks and monthly thereafter to ensure proper working order of the new latches. Any issues will be logged on the QA summary log to be discussed at the monthly QA meetings. Corrective action will be complete by 9/20/12.	09/20/2012

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	at the time of observation, the door were equipped only with deadbolts which were locked when the kitchen was not in use. 3.1-19(b)			

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K0038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 4 of 6 exits were readily accessible for residents without a clinical diagnosis requiring specialized security measures. LSC 19.2.2.2.4 requires doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1 requires door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the residents require specialized security measures for their safety, provided staff can readily unlock such doors at all times. This deficient practice could affect all of the resident room halls and therefore affects 52 resident. Findings include:	K0038	**K038** Codes were posted on all exit doors on 8/27/12. All residents had the potential to be affected by this deficiency. The QA tool titled "Life Safety Review" (Attachment B) will be completed by the Maintenance Director or designee 2x weekly for 2 weeks, weekly for 2 weeks and monthly thereafter to ensure security codes remained posted at each facility exit. Any issues will be logged on the QA summary log to be discussed at the monthly QA meetings. Corrective action will be completed by 9/20/12.	09/20/2012

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	Based on observation with the Environmental Supervisor on 08/21/12 during the tour from 12:10 p.m. to 1:30 p.m., the emergency exit doors in the 100, 200 and 300 halls as well as the 200 hall nurses' station were magnetically locked and could be opened by entering a code, but the code was not posted. Based on an interview with the Environmental Supervisor at the time of observations, the facility does not take residents having a diagnoses requiring specialized security measures. This was confirmed by the Administrator at 1:45 p.m. during the exit conference 3.1-19(b)			

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K0064 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 1 of 3 fire extinguishers located in the 200 hall was provided maintenance when the gauge on the fire extinguisher indicated it needed recharging. NFPA 10, Standard for Portable Fire Extinguishers, in Section 4-4.1 requires fire extinguishers to be subjected to maintenance no more than one year apart or when specifically indicated by inspection. This deficient practice could affect 26 residents in the 200 hall. Findings include: Based on an observation with the Environmental Supervisor on 08/21/12 at 12:17 p.m., the gauge on the portable fire extinguisher located near resident room 201 indicated the extinguisher needed to be recharged. This was acknowledged by the Environmental Supervisor at the	K0064	**K064** The fire extinguisher on the200 unit was replaced with a fully charged extinguisher on 8/23/12. All residents residing on the 200 unit had potential to be affected by this deficiency. The QA tool titled "Life Safety Review" (Attachment B) will be completed by the Maintenance Director or designee 2x weekly for 2 weeks, weekly for 2 weeks and monthly thereafter to ensure that each fire extinguisher is fully charged and in proper working order. Any issues will be logged on the QA summary log to be discussed at the monthly QA meetings. Corrective action will be completed by 9/20/12.	09/20/2012

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	time of observation. 3.1-19(b)			

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K0076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen were provided with ventilation. This deficient practice could affect 18 resident evacuated through the 300 hall exit door near the nurses' station. Findings include: Based on observation with the Environmental Supervisor on 08/21/12 at 11:55 a.m., the oxygen transfilling/storage enclosed plastic shed containing five large liquid oxygen containers was not vented to the outside. This was confirmed by the Environmental Supervisor at the time of observation.	K0076	**K076** On 9/12/12 a 6 inch by 14 inch vent was installed in our exterior oxygen storage (Vent Pic1, Vent Pic2). This will provide an additional 84 square inches of ventilation to the outside. All residents residing on the 300 unit had potential to be affected by this deficiency. The QA tool titled "Life Safety Review" (Attachment 1) has been updated to review the oxygen storage shed ventilation and will be completed by the Maintenance Director or designee 2x weekly for 2 weeks, weekly for 2 weeks and monthly thereafter to ensure the ventilation system is free from any blockage and in proper working order. Any issues will be logged on the QA summary log to be discussed at the monthly QA meetings.	09/20/2012

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K0144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 generators was in accordance with NFPA 99, 1999 Edition, Standard for Health Care Facilities. NFPA 99, Section 3-4.1.1.15 requires a remote annunciator to be provided in a location readily observed by operating personnel at a regular work station. NFPA 101, Section 4.6.12.1 requires any device, equipment or system required for compliance with the provisions of the Code shall be continuously maintained in accordance with applicable NFPA requirements. NFPA 72, National Fire Alarm Code, in 7-4.3 requires all apparatus requiring resetting to maintain normal operations shall be reset as promptly as possible after each test and alarm. This deficient practice could affect all occupants. Findings include:	K0144	**K144** The generator annunciator panel was immediately reset on 8/21/12. All residents could have been affected by this deficiency. The QA tool titled "Life Safety Review" (Attachment B) will be completed by the Maintenance Director or designee 2x weekly for 2 weeks, weekly for 2 weeks and monthly thereafter to ensure the generator annunciator panel is in proper working order. Any issues will be logged on the QA summary log to be discussed at the monthly QA meetings. Generator annunciator panel is also checked every Thursday by the Maintenance Director or designee and recorded in the TELS Logbook Report System. Corrective action will be completed by 9/20/12.	09/20/2012

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	Based on observation with the Environmental Supervisor on 08/21/12 at 12:35 p.m., the audible alarm was silenced and a common fault indicator red light was flashing on the generator annunciator panel located at the main nurses' station. Based on an interview with the Environmental Supervisor who placed a phone call to the Maintenance Director at the time of observation, he manually tests the generator and forgot to return the generator transfer switch to the automatic mode when finished. The Maintenance Director further indicated the generator would automatically start in an emergency from manual mode. It was then pointed out by this surveyor that if a problem did develop with the generator preventing the emergency operation, the annunciator panel already silenced with blinking red lights would prevent the facility from being made aware of the problem. 3.1-19(b)			

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